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AUTHOR Sales, Amos
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ABSTRACT

Individuals with substance abuse problems present a critical problem in the United States. Outside the social and economic losses presented by these problems, personal devastation is severe and usually ongoing. Many individuals with substance abuse problems are unable to, or do not, access treatment, and for those who do, treatment success rates are low. Thus, there is a need to insure that counselors are available and competent to provide service within all counseling settings. Graduate school counselor preparation programs should insure graduates are effective in counseling individuals with substance abuse problems. Effective counseling is proposed as holistic, individual based, and a person centered process. It emphasizes empowering the client, not treating the substance abuse problem. Counseling professions are identified, discussed, and found in most cases to be deficient in relation to developing counseling skills with individuals presenting substance abuse problems. Counselors, counselor education programs, and their related associations and accrediting bodies must begin to insure this expertise exists for the critical problem of substance abuse within our society to be addressed. Also included is a facilitator's manual which is a practical guide for teaching content through guided experiential projects. Five objectives are listed, and five student exercises are provided. (Contains 29 references.) (MKA)

Substance Abuse and Counseling : An Introduction .

Amos Sales

Substance abuse is a critical problem in the United States across all segments of the population. Inaba, Cohen, & Holstein (1997) provide data in support of the conclusion that substance abuse is the most prevalent mind disorder, the number one continuing health problem, and the number one prison problem in the United States. Substance abuse has received much attention in the popular as well as professional literature in recent years. The difficulties of public figures with various illicit substances receive almost weekly attention in the media. Given this visibility, the high incidence of substance abuse in our society, the economic costs, and the price in human suffering, it is imperative that counseling professionals are educated about substance abuse as a disability. Unfortunately, there is a lack of sufficiently educated counselors with skills to counsel individuals who have substance abuse problems.

A gap exists between the understanding and skills demanded of practitioners and the existence of graduate preparation programs offering this component as part of their curriculum. The need to establish a means in both preservice and inservice settings for practitioners to gain knowledge and expertise in substance abuse is easily documented.

All counselors, no matter what their professional specialty or setting, will encounter clients with presenting or related problems of substance abuse. Research shows that from one third to one half of clients on social service caseloads have an undiagnosed substance abuse problem. (DiNitto and Swab, 1991; Ohlmer, 1992). Thus, it is critical that all counselors in practice or in counselor preparation programs understand the process of substance abuse and addiction and related prevention and treatment strategies (Benshoff, 1990; Greer, Roberts, May & Jenkins, 1985).

Substance Abuse Defined

Professionals and the public face a multitude of terms used to identify individual abuse of substances. Addiction, alcoholism, alcohol abuse, drug abuse, and chemical dependency are representative. Most professionals and treatment programs now adhere to the related terms and criteria as identified in the *Diagnostic and Statistical Manual IV (DSM IV)* (American Psychiatric Association, 1994). In the *DSM IV*, previous terms are replaced by categories for the term "Substance-Related Disorders," which relates to the active use and dependency, or both on any mood-altering chemical, and "Substance-Induced Disorders," which are due to ingestion or exposure to a substance. Subcategories of "Substance-Related Disorders" are "substance dependence" and "substance abuse." The Substance-Induced Disorders include "substance intoxication" and "substance withdrawal." Substance dependence is the more severe diagnosis than substance abuse and is identified as the dysfunctional use of chemicals upon which the individual has become dependent. This dependence is equivalent to alcohol and drug addiction. Full diagnostic criteria from the *DSM IV* are provided in Chapter 2.

Substance abuse per the *DSM IV* refers specifically to the temporary abuse of a substance due to transient stresses. Within this text, we predominantly have used the term "substance abuse" interchangeably with the broad *DSM IV* term and criteria for "Substance-Related Disorders." The authors utilize the term "substance" to define alcohol, sedatives, amphetamine, cannabis, cocaine, hallucinogens, inhalants, opioids, caffeine, nicotine, and prescription drugs, as well as legal drugs. The legal nature of some drugs presents different issues related to their use and abuse than those related to illegal drugs.

While the above definition is provided for understanding in further references in this text, the beginning practitioner must understand that individuals with substance abuse cannot be categorized and defined by their substance abuse problem. An individual with a substance abuse problem is unique in his/her history, pattern of use or abuse, and treatment needs.

An individual's involvement with substances or substance use is often described as being on a continuum from non-use to dependence. The first involvement is experimental use based on curiosity. It is sporadic, episodic, and relates to a desire to experience or "tryout" the drug by testing its physical, social, or both activity effects. This use may be influenced by modeling of peer-groups or parents. Next is recreational use, which is occasional and situationally controlled. It is associated with social or recreational activities in which the user would take part whether or not drugs were present. Enjoying the total experience is characteristic of this involvement

wherein little or no effort is devoted to seeking out the drugs.

Next in the sequence is early dependence wherein the individual begins to believe the substance, person, or activity will improve his/her life and is sought out for such improvement. Negative features of involvement are not acknowledged. At the end point of the continuum is dysfunctional use. At this point, the individual begins to need a person, substance, or activity to feel normal. Friendships, work, and health begin to suffer because of the abuse. Denial, anxiety, and depression begin to occur. The individual feels miserable and uncomfortable when involved with the substance, person, or activity but is not willing to stop involvement. He/she must have "it" to survive. An awareness of this continuum leads to the obvious conclusion that there are varying degrees of involvement with substances and varying degrees of substance abuse. Some users are very conventional in every aspect of their lives except for their drug abuse while others are deeply involved in dysfunctional drug use and criminal activity to support it.

Until recently, the emphasis in treatment and prevention has been on the substance, i.e., "the demon rum," as if it were inherently alive and evil in itself (Brill, 1981). Fortunately, the current view is that substance abuse is a function of the person involved rather than the substance itself. Heavy dependence on drugs depends on the person not the drug. Given all the potential physical, cultural, and social influences, it is the personality of the user that determines how important substance use becomes "...whether it will dominate his or her life, become a recreational activity, or be dropped entirely" (Brill, 1981, p. 27.) Thus, it is the person who must be targeted in prevention and treatment of problems of substance abuse.

Causation

As is documented in an overview section on Etiology of Substance Abuse in Chapter 2, the individual use of drugs has been existent throughout recorded history to enhance a person's pleasure, alter one's state of consciousness, or decrease pain. The excessive use and abuse of substances by individuals has been viewed from differing cultural perspectives across time.

To date, no clear etiology or causation has been identified for substance abuse. Many models or theories of causation for substance abuse or addiction have been proposed. In the moral model of causation, substance abuse is viewed as a result of individual conscious choice of overindulgence and moral degradation. A cure could be obtained through willpower and a desire to abstain. The biological-disease model identifies substance abuse as biologically inherited and medically defined and caused by some biomedical reason to be vulnerable to a given substance. Avoidance of the "carcinogen" is the cure. Behavioral models view substance abuse as a result of faulty learning patterns and related ineffective attempts at stress reduction. Behavioral interventions are emphasized for treatment. Cultural models identify substance abuse as being fostered by cultural factors, social pressures, and environmental conditions. Treatment relates to developing social skills. The majority of practitioners and researchers currently support a biopsychosocial model which holds that substance abuse is developed as a result of a complex interaction of factors identified in all of the above models. This model identifies substance misuse, abuse, and addiction as multifaceted problems that vary across individuals, their cultures, and their families. In this model, multiple strategies of counseling from the other models are proposed as appropriate to treatment.

Research in support of any of these models is inconclusive. There is no clear consensus as to why people engage in substance abuse, and why some people become addicted (Erickson, 1998). Despite this, it is important for the beginning counselor to develop a conceptual position through a review of various models that attempt to explain substance abuse and related addictive disorders. From this review, the counselor can develop a position upon which he/she can make consistent therapeutic assumptions and decisions to guide counseling practice.

Prevalence

As is the case of problems with identifying specific terminology related to substance abuse, the difficulty of identifying specific incidence and prevalence data exists. Surveys and self-reports are replete with validity problems. Individuals who abuse one drug often abuse another and their individual reporting of use compounds the survey data. Thus, estimates of the prevalence of substance abuse problems in the population at large range from a low of 2% to a high estimate of 60%.

For the past five years, substance use has been viewed by the general population as the primary problem

facing our society. Data from the 1996 National Household Survey on Drug Abuse (NHSDA) show that alcohol and cigarettes are the substances most frequently used. A majority of the respondents aged 12 and older reported that they had used alcohol (51%) at least once in the month prior to the survey. The next highest reported use was cigarettes (29%), followed by marijuana (5%), and smokeless tobacco (3%). Use of all other drugs was reported by 1% or less of the respondents. National statistics (National Institute on Drug Abuse [NIDA], 1993) indicate an increase in drug usage of various substances across all age groups.

It is difficult in reviewing the literature to estimate with any degree of accuracy the number of individuals who chronically abuse substances. Available statistics are usually cited for specific substances such as alcohol, cocaine, marijuana, or prescription medications. As was indicated earlier, references in the literature point to the fact that many individuals abusing one substance tend to abuse others, which makes it all the more difficult to determine the true extent of this problem.

Illicit Drugs

The National Institute of Drug Abuse (NIDA) Household Survey (1993) indicated that 5.6% of adults surveyed met the criteria for drug use and dependence. It is estimated that more than 2% of the population, about 5.5 million people, need treatment for drug abuse (Gerstein & Harwood, 1990). One in 35 Americans older than 12 abuses illicit drugs (NIDA, 1996). Thirty-seven percent of the population over the age of 12 indicate they have used illegal drugs. Twelve percent are current users. Additionally, over twenty million Americans use marijuana regularly, approximately eight million are regular cocaine users, and two million are heroin addicts.

Alcohol

In 1992, approximately 13.8 million United States citizens had problems with drinking, including 8.1 million who are alcoholic (National Institute of Alcohol Abuse and Alcoholism, 1994). Greer (1985) cites estimates of "heavy drinking" in the United States as 12 % and the prevalence of problem drinking among American males is considered to be as high as 20%. More than 500,000 Americans are treated yearly in more than 8,000 inpatient and outpatient alcohol treatment programs.

Prescriptions

Approximately 1.5 billion prescriptions are written each year in the United States. Over the past 25 years, the average annual number of prescriptions per person has increased from 2.4 to 7.5 (Stall, 1996). Investigators estimate that 13% of the men and 29 percent of the women in the United States use some form of psychotropic drug. The abuse of prescribed drugs in the United States may be as high as 20 percent of the general population (Hazelden, 1996).

Nicotine

One in four, or approximately 56 million, are addicted to nicotine (Inaba and Cohen, 1991). Fifty million smoke cigarettes and 6.1 million are current users of smokeless tobacco (Substance Abuse and Mental Health Services Administration, 1994).

Of obvious concern related to abuse of substances in our society is the early initiation to drugs. One in 3 teenagers by age 16 indicates he/she has been approached to buy or use drugs, and at least 4 of 10 school children say drugs are being sold in their schools (Gallup Poll, 1989). One in 10 high school students has used cocaine at least once and more than 1 in 5 teens have used illegal drugs (National Institute of Drug Abuse, 1991).

Prevalence figures indicate there is a major problem of substance abuse among individuals within our society. The estimates indicate approximately 6% of our population abuse illegal drugs, 12% have problems with drinking, 25% are addicted to nicotine, and conservatively 10% are addicted to prescription medications. Cumulatively, these percentages reflect a significant number of the United States population having a substance abuse problem. Substance abuse impacts in some way all members of our society at all ages.

Counseling Perspectives

A major perspective of this text is that counselors must avoid earlier thinking which stereotyped all individuals with substance abuse problems as "substance abusers" who have uniform characteristics treatable by one treatment approach. There is as great a diversity in substance abuse as there are individuals who abuse substances. While the abuse of substances across individuals has some similarities, the individual and his/her substance abuse problem is unique. Effective prevention and treatment strategies must target the individual with a substance abuse problem not the substance abuse problem.

Conclusions regarding effective counseling strategies for counseling individuals with substance abuse are limited in that this counseling specialty area has been driven more by experience and clinical intuition than by research. As a result, most traditional substance abuse treatment programs (e.g., Alcoholics Anonymous, alcoholism education, half-way house and therapeutic communities utilizing confrontation, group therapy, individual counseling, and use of medication) have not demonstrated their efficacy. Some successful treatment outcome has been linked to short-term interventions, aversion therapy, stress management, solution-focused brief therapy, and social skills training, yet seldom are these methods utilized in traditional substance abuse treatment programs in the United States. Given this, conclusions regarding counseling and substance abuse have to come from general counseling research data.

Counselors, regardless of their settings, impact as change agents within the context of therapeutic relationships with individuals. Counselors become more invested in the process and who utilizes therapeutic techniques appropriate to the client. A thorough review of *Counseling Outcome Research* (Sexton, Whiston, Bleur, and Walz, 1997 pp. 58-62, pp. 87-93) concludes the following:

- 1) Counseling is a process beneficial to most clients of skilled counselors. However, it is not always so. A significant number of clients get worse;
- 2) Counseling models (e.g. cognitive, experiential, behavioral, dynamic) are effective and when compared seem equivalent in their effect on counseling outcome.
- 3) Successful counseling has common factors which are consistently related to success and evident across various counseling models. These factors include "support" factors leading to the establishing of an open, trusting, collaborative relationship with the client, "learning" factors such as advice, corrective emotional experiencing, and feedback, and "action" factors including behavior regulation, cognitive mastery, and successful experiences.
- 4) Successful counseling outcome is dependent on counselor therapeutic skills such as focusing conversations on life problems, addressing presenting problems directly, and providing structure for counselor-client intervention, and
- 5) Successful counseling progresses through various process stages wherein different types of counselor-client interaction are reflected by different counseling techniques.

The above research conclusions support the following perspective regarding counseling with clients with substance abuse problems. Counselors, to be effective, first must have the ability to develop an open, collaborative relationship with clients wherein clients perceive trust and commitment. Carl Rogers identifies, and research supports, this ability as related to the counselor's skill in conveying, in interaction with clients, unconditional positive regard and empathic understanding (Austin, 1999). Within this relationship, the counselor must provide focus for the process by addressing the client's presenting problems directly and identifying client need for change. Counselors of clients with substance abuse problems often find this process difficult because of the chronic nature of interrelated destructive attitudes and coexisting disorders these clients often bring to counseling. Once problem identification and client need for change are identified, the counselor must be able to articulate and implement counseling intervention strategies perceived by both the counselor and the client as appropriate to the client's need to change.

These process considerations in counseling clients with substance abuse problems hold to be true for specialists in this area and for counselors working in school, rehabilitation, mental health, and social work settings. The counselor emphasis is on the person not the substance abuse problem. Additional knowledge and skill on the part of the counselor relates to being able to assess the extent and impact of a client's substance abuse problem and the client's need to change. Familiarity with and ability to utilize standardized assessment instruments specific to substance abuse will help the counselor in this assessment process. Familial and social environment assessment also is required to identify the extent of and to utilize the client's support systems. The counselor's ability to identify, and the quality of, counseling and related treatment intervention strategies obviously is linked to his/her assessment and diagnostic skills.

Counselors should be thoroughly familiar with the facilities and services in his/her community to insure proper referral for clients with substance abuse problems. Referral options are determined by client need and collaboratively agreed upon as appropriate by the counselor and client. These include short-term, inpatient care lasting three to seven days for withdrawal from substance abuse, or intensive, outpatient programs lasting eight to twelve weeks wherein clients maintain vocational and family responsibilities while participating in treatment. Another option, the half-way house, provides moderately structured and supportive residential treatment lasting for three to six months, wherein successful living within the environment becomes part of the treatment plan. Other options include therapeutic communities,

their clients, they do not dwell on their own past or worry about the future.

14. Effective counselors appreciate the influence of culture. Counselors need to be aware of how their own cultures have affected them, and how they have integrated their cultures into themselves. They should also be aware of how culture, race, and gender create different

In addition to these process and case management skills, there are other counseling considerations that are particularly appropriate for counselors working with clients with substance abuse problems. Corey (1996) has identified these as a list of 18 goals counselors in any setting should strive for to become models of awareness and growth for their clients.

1. Effective counselors have an identity. These are people who are not just doing what they think other people want from them. They are people with a solid sense of self, values, life direction, and principles that they live by. They can set goals and achieve them. They possess a certain sense of their own individuation and separateness but are also willing to evaluate their ideas.
2. Effective counselors respect and appreciate themselves. These people have good self-esteem and consider themselves to be good people. They can give and receive love, care and feel a connectedness to others.
3. Effective counselors are able to recognize and accept their own power. A counselor has power over his or her client by the nature of the relationship. A good counselor is aware of this power and uses it to help his or her client and does not abuse it. This is not to suggest a position of superiority, but to acknowledge that there is potential for abuse. It is not used to diminish others.
4. Effective counselors are open to change. There is a sense of flexibility and openness to other possibilities and growth. There is the ability to risk new behaviors for the potential of learning or experiencing something new that could make them a better person.
5. Effective counselors are expanding their awareness of self and others. These people are aware that they are limited in their experiences and move toward growth and development in themselves and learning about others' experiences.
6. Effective counselors are willing and able to tolerate ambiguity. Black-and-white, polarized thinking is prevalent in clients with chemical dependency and people who have lived with them. The ability to tolerate ambiguity means becoming comfortable with not knowing as well as exploring the gray areas of life. It is more comforting to stick with absolutes and unbending rules. It takes courage to risk the process of life and to trust that intuitions and novel ideas can produce self-growth and growth in others.
7. Effective counselors are developing their own counseling style. This process comes with experience and being open to learning. Counselors who try to exactly imitate another counselor or apply a counseling theory without modification will be less successful than if they are able to pull from many sources, including self-knowledge, to develop their own unique theories.
8. Effective counselors can experience and know the world of the client, yet their empathy is nonpossessive. This is the ability of counselors to know themselves in a way that allows them to put their own needs aside long enough to truly understand the worlds of their clients. They, however, do not lose themselves in this process. They can clearly distinguish between the clients' issues and theirs.
9. Effective counselors feel alive, and their choices are life oriented. These are people who take an active stance in life. They are not passive but are proactive.
10. Effective counselors are authentic, sincere, and honest. These are people who have demonstrated congruence between what they think, feel, and do. They do not play roles or hide behind masks. Their communication is straightforward and nondefensive.
11. Effective counselors have a sense of humor. These are people who use their sense of humor to put life in perspective. They can laugh at themselves and their mistakes. This is extremely important in treating substance abusing individuals and their families who have often forgotten, or never knew, how to laugh and play with one another. This is also the best antidote for burnout.
12. Effective counselors make mistakes and are willing to admit them. In a field where attempts at perfectionism abound, being able to admit and learn from mistakes is important to the chemical dependency counselor. They also become excellent role models for clients who hide their mistakes because of extreme guilt.
13. Effective counselors generally live in the present. Counselors who can live in the present are more available to their clients. Although the past may be interesting and useful in understanding

- experiences for others. They need to respect the differences of others.
15. Effective counselors are able to reinvent themselves. These are people who are always in the process of self-growth and can change themselves for the better. They have clear ideas of the person they would like to be, and they move in that direction.
 16. Effective counselors are making choices that shape their lives. These people do not allow previous mistakes or incorrect decisions to make them victims. They learn from mistakes and make good choices based on continual self-evaluation.
 17. Effective counselors have a sincere interest in the welfare of others. Their work is based on a genuine respect and desire to help others. They can respect and care for those they are helping.
 18. Effective counselors become deeply involved in their work and derive meaning from it. These counselors enjoy the process of helping others and look forward to going to work. They recognize the ego needs that are met by helping others, yet they know how to balance their lives and are not workaholics. (In Lawson, Lawson, & Rivers, 1996, pp. 4-6.)

Who Counsels?

The question of what personal and professional qualifications a counselor needs continues to be debated. Those in "treatment camps" with the perspective of treating the problem are committed to the belief that an effective counselor must be a recovering substance abuser who has experienced the disability, treatment, and "cure". Others, more oriented to counseling individuals, advocate training and clinical experience with clients who have substance abuse problems leading to a master's degree in counseling. In relation to the major debate in the substance abuse counselor field as to whether or not recovering or nonrecovering counselors are better able to treat individuals who have substance abuse problems, a survey of administrators of substance abuse programs believe the two groups do not differ in effectiveness (Anderson & Weimer, 1992). Counselor "effectiveness" across both groups relates more to the counselor person-related qualities and abilities identified throughout this text.

Counselors—Experience Based: Substance abuse counselors, since the birth of *Alcoholics Anonymous* in 1935, have "come from the ranks." They predominantly have been individuals who have overcome a drug or alcohol problem and have a commitment to helping others do the same. Thus, many substance abuse counselors entered the field and were credentialed based on their own recovery experiences. The predominant view in substance abuse counseling for at least four decades was that personal experience, not professional training, was the prerequisite to practicing as a counselor.

National Public Policy changes in 1970 began to impact this counseling view. In that year, the Hughes Act (Public Law 91-616) established the National Institute for Alcohol Abuse and Alcoholism (NIAA) to fund alcoholism research, and addiction treatment began to be reimbursed by insurance companies (O'Dwyer, 1993). The Hughes Act also funded states to establish alcohol units or divisions which funded treatment programs for federal employees (Fisher and Harrison, 1997). With these changes, states began in the 1980s to create licensing bodies to ensure the quality of counseling to substance abusers (O'Dwyer, 1993). Being a recovering addict no longer meant immediate access to employment as a substance abuse counselor. Instead, documentation of a combination of credentials regarding both counseling experience and training was required by states to practice.

The predominant number of substance abuse counselors in the United States identify with either the National Association of Alcoholism and Drug Abuse Counselors (NAADC) or the American Academy of Health Care Providers in Addictive Disorders (AAHCPAD) through which they receive certification. The NAADC code of ethics is specific to practice with individuals who are substance abusers. NAADC has different levels of counselor certification depending on training and experience and requires a written examination at each level. AAHCPAD provides the Certified Addiction Specialist (CAS) credential to degreed persons with two years experience or to non-degreed persons with five years experience. No written examination is required. Few, if any, insurance companies will pay reimbursement for service unless it is provided by a certified mental health professional.

Counselors—Master's Level: Over the years, the word counselor has simply meant any "professional who practices counseling" (Chaplin, 1975, p. 120). More frequently because of legal and certification issues, individuals who refer to themselves as counselors will have master's degrees in counseling. While there are many different professional identities of counselors, all have shared common coursework in their master's degree programs of study, i.e., professional orientation, the individual and group counseling relationship, ethics, supervised practice in counseling, career development, appraisal, and social and cultural foundations. In addition to these, students will generally take specialty coursework linked to roles and functions related to knowledge and skills required

within a specific work setting.

Delivery of a common core of knowledge and skill within a master's in counseling sequence of study dates back to early 1940's Veterans Administration guidelines for a two-year sequence of study leading to a designation of "psychological counselor." Evolving from this model was rehabilitation counseling, the specialty emphasizing counseling with individuals with disabilities. It was the first counseling specialty to develop a national accrediting body, the Council on Rehabilitation Education (CORE) and the first to develop a national certification process, the Commission on Rehabilitation Counseling Certification (CRCC) with the designation of Certified Rehabilitation Counselor (CRC). Utilizing this accreditation model, school counseling was the next counseling specialty to develop an accreditation and certification process. Accreditation as developed was through the Council for the Accreditation of Counseling and Related Educational Programs (CACREP). Certification was implemented under the National Board for Certified Counselors (NBCC) as National Certified Counselors (NCC). CACREP has evolved to recognize a variety of counseling specialties: community counseling, school counseling, marriage and family counseling, and mental health counseling.

Today, every state in the country has as a requirement by national law that counselors in state and federal vocational rehabilitation agencies have a master's degree and hold the CRC. Additionally, 43 states and the District of Columbia have adopted licensing laws that require a master's degree in counseling to practice as a Licensed Professional Counselor (LPC). In those states, NCC's and CRC's may be certified as LPC's.

While keeping in mind that a person obtaining a master's degree in counseling is first a counselor and second a "specialty" counselor, the following are some of the more prevalent counseling specialty areas. In all cases, the academic emphasis is on developing skills in counseling that are then applied to the specialty area. None of the following specialties have required coursework in substance abuse as a prerequisite for graduation from master's degree programs of study.

Rehabilitation Counselor: The Rehabilitation Counselor has a master's degree and works in state vocational rehabilitation agencies, unemployment agencies, or private rehabilitation agencies and counsels working age individuals who are physically or mentally disabled. Specialty knowledge and skill relates to this population. While there is no requirement by CORE for accredited master's degree programs in rehabilitation to have expertise in substance abuse as a requirement of graduation, CRCC did recognize in 1993-94 a growing specialty in rehabilitation counseling and substance abuse. It developed an additional and new certification procedure for Certified Rehabilitation Counselor: Substance Abuse Counselor (CRC-SAC). This certification requires an additional 12 semester hours of coursework specific to substance abuse counseling, a minimum of one year of supervised acceptable work experience and documentation of supervision by a CRC or related professional. Rehabilitation counselors identify with and join the professional organizations of the National Rehabilitation Counseling Association (NRCA) a professional division of the National Rehabilitation Association (NRA) or the American Rehabilitation Counseling Association (ARCA), a professional division of the American Counseling Association (ACA).

School Counselors: Historically, the counselor in the school setting has been called the guidance counselor. Recently, many educators and practitioners have tried to replace that term with school counselor in an attempt, of varying success, to de-emphasize the guidance activities of the school counselor. Credentialing by some state departments of education is on elementary, middle, and secondary levels and, in others, credentialing covers kindergarten through the twelfth grade. Some states, but not all, require that school counselors have teaching experience.

CACREP does not identify the delivery of substance abuse content as a requirement for accreditation master's degree programs in school counseling, although it does recommend that counselor education programs address prevention and treatment in this area. The school counselor's usual professional association of choice is the American School Counselor Association (ASCA), which is a professional division of the American Counseling Association (ACA).

Mental Health Counselor/Agency Counselor/Community Counselor: These counseling specialties require the master's degree and specialty preparation in their designated area. Although CACREP differentiates community counseling from mental health counseling, which requires more extensive training, individuals with these degrees work in similar settings, public agencies, or private practice. These counselors usually become LPC's if their state has a licensing procedure.

As is the case in school counseling, knowledge and skill specific to substance abuse is not required but recommended for CACEP accreditation in these specialties. The NBCC established in 1995 an addiction certification specialty for mental health counselors. In 1997, NBCC developed the Master's in Addiction Counseling (MAC) certification wherein counselors certified as addiction counselors by CRCC, NBCC, and

NAADC could qualify. The usual choice of these counselors of a professional organization is the American Mental Health Counselor's Association (AMHCA), a professional division of ACA.

Social Workers: The term, social worker, can apply to graduates of either an undergraduate or graduate degree program in social work. Usually, the social worker has completed a master's degree in social work (MSW). While many differences exist in philosophy and theory between the master's degree in social work and the master's in counseling, the two have more similarities in curriculum than differences. Substance abuse knowledge and skill is not a requirement within MSW programs. MSW's can become nationally certified by the Academy of Certified Social Workers (ACSW), and most states have specific requirements for licensure as a Licensed Clinical Social Worker (LCSW). The National Association of Social Workers (NASW) is the professional association of choice for social workers.

The professional associations linked to the above professions have evolved as a means to protect the rights of their members and their clients and to enhance professional practice in the specialty area. These associations monitor professional practice through requiring member adherence to ethical standards and practice. They also provide access to continuing education through national, regional, and state conferences and workshops, impact national legislation through education and lobbying efforts, and provide a wide variety of member benefits such as insurance, job banks, and interest networks. It is beyond the scope of this publication to discuss associations in detail. It is important, however, to emphasize that individual counseling practice is governed by codes of ethics and standards of practice which should be well understood and followed no matter what the specialty area of counseling practice.

As is noted in the above discussions, counselor education programs appear to be deficient in their response to the major problem of substance abuse within our society. Most currently do not require knowledge or skill of graduates in this critical area. Counselor education programs must become more progressive and aggressive in insuring that their graduates have counseling knowledge and skill related to counseling individuals with substance abuse problems. Accreditation bodies, as well as professional organizations, could and should provide leadership for needed improvement in this area.

Summary

Individuals with substance abuse problems present a critical problem in the United States. Outside the social and economic losses presented by these problems, personal devastation is severe and usually ongoing. Many individuals with substance abuse problems are unable to, or do not, access treatment and of those who do, treatment success rates are low. Thus, there is a need to insure that counselors are available and competent to provide service within all counseling settings. Counselor preparation should insure graduates are effective in counseling individuals with substance abuse problems.

Effective counseling is proposed as holistic, individual based, and a person centered process. It emphasizes empowering the client, not treating the substance abuse problem. Counseling professions are identified, discussed, and found in most cases to be deficient in relation to developing counseling skills with individuals presenting substance abuse problems. Counselors, counselor education programs, and their related associations and accrediting bodies must begin to insure this expertise exists for us to be able to address the critical problem of substance abuse within our society.

References

- American Psychiatric Association: (1994). *Diagnostic and statistical manual of mental disorders*, (4th ed.). Washington, DC: Author.
- Anderson, S. & Weimer, L. (1992). Administrators' beliefs about the relative competence of recovering and nonrecovering chemical dependency counselors. *Families in Society: The Journal of Contemporary Human Services*, 73 (10), 596-603.
- Austin, L. (1999). *The counseling premier*. Philadelphia, PA: Accelerated Development.
- Benshoff, J. J. (1990). Substance Abuse: Challenges for the rehabilitation counseling profession. Editorial. *Journal of Applied Rehabilitation Counseling*, 21 (3), 3.

- Boy, A. & Pine, J. (1990). *A person-centered foundation for counseling and psychotherapy*. Springfield, IL: Charles C. Thomas Publishing.
- Brill, L. (1981). *The clinical treatment of substance abuse*. New York: Free Press Macmillian.
- Chaplin, J. P. (1975). *Dictionary of psychology (2nd ed.)*. New York: Dell.
- Corey, G. (1996). *Theory and practice of counseling and psychotherapy (5th ed.)*. New York: Brooks/Cole Publishing Company.
- Davis, S. & Meier, S. (1997). *Elements of Counseling (3rd ed.)*. New York: Brooks/Cole Publishing Company.
- DiNitto, D. M., & Schwab, A. V. (1991). *Substance abuse factors which interfere with entry or reentry into employment*. Austin: University of Texas, School of Social Work.
- Erickson, S. (1998). Ethological theories of substance abuse. In Stevens-Smith, P., & Smith, R. R. *Substance abuse counseling* (pp. 25-64). Columbus, Ohio: Prentice Hall.
- Fisher, S. L., & Harrison, T. C. (1997). *Substance abuse: Information for school counselors, social workers, therapists, and counselors*. Boston: Allyn and Bacon.
- Gallup Poll (1989, August 4). pp. 10,16.
- Gerstein, D. R., & Harwood, H. J. (1990). *Treating drug problems*. Vol. 1, Washington, D.C.: National Academic Press.
- Greer, B. G., Roberts, R., May, G., & Jenkins, W. M. (1985). Identification of substance abuse in a vocational evaluation setting. *Journal of Rehabilitation*, 54 (3), 42-45.
- Hazelden Corporation. (1996). *Alcoholism and drug abuse: A growing problem with the elderly*. On the World Wide Web, 1-2.
- Helwig, A. A. & Holicky, R. (1994). Substance abuse in persons with disabilities: Treatment considerations. *Journal of Counseling and Development*, 72 (31), 227-233.
- Inaba, D. S., Cohen, W. E., & Holstein, M. E. (1997). *Uppers, downers and all arounders: Physical and mental effects of drugs of abuse*. Ashland: CNS Publications.
- Lawson, G. W., Lawson, A. W. & Rivers, P. C. (1996). *Essentials of chemical dependency (2nd ed.)*. Gathersburg, MD: Apen Publishers, Inc.
- National Institute of Alcohol Abuse and Alcoholism. (1994). *Alcohol Health and Research World*, 18 (3), 243, 245.
- National Institute of Drug Abuse. (1991). *An economical approach to addressing the drug problem in America*. Rockville, MD: Author.
- National Institute of Drug Abuse (1993). *National household survey on drug abuse and population estimates 1990*. Rockville, MD: Author.
- National Institute of Drug Abuse. (1996). *Preliminary results of the 1996 national household survey on drug abuse*. Rockville, MD: Author.

- O'Dwyer, P. (1993) Alcohol treatment facilities. In S. L. A. Straussner (Ed.), *Clinical work with substance abusing clients* (pp. 119-134). New York: Guilford.
- Ohlmer, V. L. (1992). *Undetected substance abuse among vocational rehabilitation clients*. Dissertation. University of Arizona.
- Pines, M. (1998). *Circular reflections: Selected papers on group analysis and psychoanalysis*. Philadelphia, PA: Jessica Kingsley Publishers.
- Sapp, M. (1997). *Counseling and psychotherapy: Theories, associated research, and issues*. New York: University Press of America, Inc.
- Stall, R. S. (1996). Drug abuse in the elderly: Major issues. On the World Wide Web, 1-3.
- Yalom, I. (1995). *The theory and practice of group psychotherapy* (4th ed.). New York: Basic Books, Inc.

Substance Abuse and Counseling: An Introduction

Amos Sales

Substance abuse is a critical problem in the United States across all segments of the population. Given this problem, it is imperative that counseling professionals are educated about substance abuse as a disability. All counselors, no matter what their professional specialty or setting, will encounter clients with presenting or related problems of substance abuse. Thus, it is critical that all counselors in practice or in counselor education programs understand the presenting problems of clients with substance abuse issues and addiction and related prevention and treatment strategies.

Overview

This chapter briefly defines substance abuse and its causation and prevalence. Counseling perspectives related to working with individuals with substance abuse problems are discussed. The types of counselors working with clients with substance abuse problems is identified.

Objectives

1. To identify the definition of substance abuse as utilized within the text.
2. To increase awareness of why the development of a personal position on causation of substance abuse problems is of importance to counselors.
3. To increase awareness of the prevalence of substance abuse in our society.
4. To increase understanding of counseling perspectives and goals important in counseling individuals with substance abuse problems.
5. To increase understanding of who counsels individuals with substance abuse problems in our society.

Activities

Exercise I: Options Linked to Objective 1

1. Ask students to discuss the difference between self-medicating with non-prescription drugs for physical pain and discomfort and self-medicating with mind-altering substances for psychic pain and discomfort.
2. Ask students to brainstorm a list of chemical substances that they use to make themselves feel better or relieve pain. Write the list on the board. Ask students to take each example and describe a situation where it is used constructively (if any) or destructively.

Examples:

- coffee, tea, or cola
 - over-the-counter drugs such as aspirin, cough and cold remedies, antacids, etc.
 - alcohol
 - cigarettes
 - marijuana or other illegal drugs
3. Have students brainstorm and list expressions and ad slogans that promote alcohol use ("Happy Hour," etc.). Then have students describe the images evoked by these slogans.
 4. Have students record the number of messages promoting use of alcohol or other drugs seen in a 24-hour period. Include source of message, name of chemical substance, and brief content description; or have students keep track of messages on TV related to use of alcohol or other drugs during a major sporting event. Discuss any conflicting messages.

Exercise II: Options Linked to Objective 2

1. Brainstorm with the class about reasons why people use drugs. Have several students write down the answers on either the blackboard or flip chart. Remind students that brainstorming does not involve

judgments. All comments are accepted "as is" with the exception of asking for clarification to ensure that a student's idea has been accurately captured.

Use the list to begin a discussion that encourages students to examine sociodemographic variables, personality factors, family influences, and the desire for enhanced appearance, recreation, and other major influences that promote substance abuse among youth. The following questions may help students explore these varied reasons:

- What have you become aware of during this brainstorm?
- In what way might it be important or unimportant for counselors to understand these complex reasons?
- Given the many reasons why kids may be using drugs, what role can the school be expected to play in prevention?

Summarize what the class has discussed, emphasizing major risk factors and the need to be sensitive to and respectful of individual differences. Point out stereotypes regarding drug use and reinforce how responding to these generalizations is not helpful in developing and nurturing responsible people.

2. Have students brainstorm reasons for substance use and abuse, and transcribe student responses on large sheets of newsprint or blackboard.

Examples: boredom, stress, recreation, low self-esteem, peer pressure, rebellion

List as headings across the board or paper the various prevention approaches that have been employed since the turn of the century:

- moral objection (1900s)
- legal sanctions (1920s)
- scare tactics (1930s and 1940s)
- drug education (1960s)
- effective education (1970s)
- social skills training (1970s and 1980s)
- health and wellness emphasis (1980s)
- alternative activities (1980s)

Examine each reason for substance abuse and list it under the prevention approaches that are most likely to be effective in addressing the underlying motivations.

Example:

Wellness	Scare Tactics	Affective Education	Alternative Activities
Recreation	Rebellion	Low self-esteem	Recreation
Boredom		Peer pressure	Boredom
Stress		Stress	Holidays
Low self-esteem			

Finish this activity by facilitating classroom discussion that focuses upon two points:

- (1) people use substances for different reasons; and
- (2) each of the various approaches to prevention and treatment are associated with some (but not all) of these reasons.

Exercise III: Options Linked to Objective 3

1. Have students break into groups of four to five to have individual members discuss the impact of substance abuse on their lives. Have them identify whether family, friends, or acquaintances have had substance abuse problems. Per personal experience, what do individuals view as the prevalence of substance abuse problems in our society? Leave time for large group discussion of this activity.

Exercise IV: Options Linked to Objective 4

1. Have students work in small groups of four or five to generate ideas for specific counselor behaviors that 1) may help to counteract risk factors among their clients for later substance abuse and 2) may help such clients overcome substance abuse problems.
Leave sufficient time for a designated member from each group to report the group's ideas to the

entire class. Summarize input, reinforce appropriate counseling perspectives and goals.

Exercise V: Options Linked to Objective 5

1. Have class break into groups of four or five members. Identify one counseling specialty per group, i.e., school counseling—group one, rehabilitation counseling—group two, etc. Have groups brainstorm and have a recorder list the types of substance abuse problems that their designated counselor might face. Leave time for groups to report to full class. Discuss similarities and differences, if any, across groups.